



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MADHAVAN PISHARODI MD
3475 W ALTON GLOOR BLVD
BROWNSVILLE TX 78520

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-09-A123-01

MFDR Date Received

JULY 8, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per rule 134.202(b) research of policies for this HCPSC code reveals that policy changes made in January of 2002 allow for separate reimbursement for each electrode rather than arrays. The HCPCS code used for implantable neurostimulator electrodes changed from E0752 to L8680 in January 1, 2006. Additionally, it is our understanding that the Workman's Compensation pays at 125% of the Medicare fee schedule. Our claim was not paid accordingly and we believe additional payment is warranted."

Amount in Dispute: \$6,932.62

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor has not documented by his operative report or through an invoice actually how many electrode contacts are on each electrode array that were placed. Texas Mutual paid two, one for each electrode array."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2009	HCPCS Code L8680 (16)	\$6,932.62	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 Explanation of benefits
 - CAC-45-Charges exceed fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group codes PR or Co depending upon liability).
 - 793-Reduction due to PPO contract. PPO contract was applied by Focus/Beech Street.
 - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - 891-The insurance company is reducing or denying payment after reconsideration.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Does the documentation support billed service?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:
 (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

(2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

On October 13, 2010, the Division requested a copy of the written notification to the health care provider pursuant to 28 Texas Administrative Code §133.4. No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. The requestor billed 16 units of HCPCS code L8680. HCPCS code L8680 is defined as "Implantable neurostimulator electrode, each."

The respondent states in the position summary that "The requestor has not documented by his operative report or through an invoice actually how many electrode contacts are on each electrode array that were placed. Texas Mutual paid two, one for each electrode array."

A review of the operative report indicates "The electrode was then introduced through the needle and advanced to the eighth thoracic vertebra...Next, the same procedure was done on the left side and the electrode was crossed on to the right side." The operative report does not document 16 electrodes were implanted; therefore, reimbursement for two is recommended (one on the left and one on the right)

3. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

28 Texas Administrative Code §134.203 (b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

28 Texas Administrative Code §134.203 (d)(1) (2)and (3) states "The MAR for Healthcare Common Procedure

Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.”

HCPCS code L8680 has a Medicare rate of \$418.95 X 125% = \$523.68. This amount multiplied times two equals \$1,047.36. The insurance carrier paid \$1,047.38. Therefore, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$ 0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	2/14/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.